Instructions to find your Explanation of Benefits (EOB) from myuhc.com to file a Gap Claim
1. Go to https://www.myuhc.com
2. You will need your United Health ID card when you register
3. Once you have a username and password...you need to remember these for future use
4. Below is the home screen for myuhc.com
5. Click on "Manage my Claims"

HOME PAGE
myuhc.com

Hello, Jane
My Coverage: Active 07/01/12
Plan Name: Choice Plus
Group/Account #: 0709004
Member ID: 801338300

Plan Details

Deductible
$1000 Individual
$2000 Family
Out-of-Pocket Max
$4000 Individual
$8000 Family

Information Center
1. Tell us what you think about paying providers online
2. Enhanced Security on myuhc.com® - Coming Soon
3. myuhc.com® mobile - Convenient Smartphone Access to Benefit and Provider Information
4. Coverage for Preventive Care

What would you like to do today?

MANAGE MY CLAIMS

LOOK UP MY BENEFITS

FIND A DOCTOR

MANAGE MY PRESCRIPTIONS

VIEW ONLINE STATEMENT

View Account Balances

PRINT ID CARD

HEALTH ASSESSMENT

Est Health Care Costs

Extra Programs & Discounts

Look Up Health Topics

Information Center

Ask a Nurse
Emergency? Dial 911
Registered nurses are available 24/7 to answer your health questions

Chat online now
Call 1-888-887-4114
Click for more information
6. Click on the down arrow on Dates Visited and select “Current Calendar Year”
7. Click on the down arrow on Family Members and select a family member
8. Click on the Claim Types and select “Medical”
9. Click on Search
10. Click on “View Claim” on the largest amount billed
Claim for Jane Doe

Visited: Arkansas Surgical
Date(s) of Service: 04/03/2014
Claim Number: 4516343037
Status: Processed 04/11/2014
Date Received: 04/10/2014

EXPLANATION OF BENEFITS (PDF)

At a Glance

Amount Billed: $3,430.09

Plan Discounts: $2,851.09
Your Plan Paid: $323.84

Your Responsibility: $255.16
Deductible: $174.20
Coinsurance: $80.96

You May Owe: $255.16

Detailed Costs

<table>
<thead>
<tr>
<th>Amount Billed</th>
<th>Plan Discounts</th>
<th>Your Plan Paid</th>
<th>Deductible</th>
<th>Coinsurance</th>
<th>Your Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/03/2014 Op Misc. Services</td>
<td>$3,430.09</td>
<td>$2,851.09</td>
<td>$323.84</td>
<td>$174.20</td>
<td>$80.96</td>
</tr>
</tbody>
</table>

You May Owe: $255.16
**Explanation of Benefits Statement**

This is not a bill. Do not pay. This is to notify you that we processed your claim.

**Claims Summary**

Detailed claim information is located on the following page(s).

<table>
<thead>
<tr>
<th>Dollar Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Billed</td>
<td>$3,938.00</td>
</tr>
<tr>
<td>Plan Discounts</td>
<td>$339.19</td>
</tr>
<tr>
<td>Your Plan Paid</td>
<td>$478.14</td>
</tr>
<tr>
<td>Total amount you owe the provider(s)</td>
<td>$317.78</td>
</tr>
</tbody>
</table>

The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, co-pay, coinsurance and/or non-covered charges. This amount does not include any payments made to the subscriber. If a payment was made directly to the subscriber, you, the subscriber, is responsible for paying the physician, facility or other health care professional.

* When coordination of benefits applies, this amount will include payments made to the subscriber.
### Claim Detail for JANE DOE

**Provider:** K ROSENZWEIG  

**Claim Number:** 451216102101  

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Type of Service</th>
<th>Notes*</th>
<th>Amount Billed</th>
<th>Plan Discounts</th>
<th>Your Plan Paid</th>
<th>Amount You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/2014</td>
<td>OFFICE VISITA 01</td>
<td></td>
<td>$90.00</td>
<td>$30.98</td>
<td>$24.38</td>
<td></td>
</tr>
<tr>
<td><strong>Claim Total:</strong></td>
<td></td>
<td></td>
<td>$90.00</td>
<td>$30.98</td>
<td>$24.38</td>
<td></td>
</tr>
</tbody>
</table>

**Your itemized responsibility to provider:**

<table>
<thead>
<tr>
<th>Deductible (+)</th>
<th>Copay (+)</th>
<th>Coinsurance (+)</th>
<th>Non-Covered (-)</th>
<th>Amount You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.00</td>
<td>$35.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$35.00</td>
</tr>
</tbody>
</table>

**This total does not reflect any payments/copays you made at the time of service. Please wait for a provider bill before making a payment.**

### Claim Detail for JANE DOE

**Provider:** ARKANSAS SURGICAL  

**Claim Number:** 451034303701  

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Type of Service</th>
<th>Notes*</th>
<th>Amount Billed</th>
<th>Plan Discounts</th>
<th>Your Plan Paid</th>
<th>Amount You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/09/2014</td>
<td>GP MISC. SERVICES</td>
<td></td>
<td>$4,250.05</td>
<td>$2,665.09</td>
<td>$333.84</td>
<td></td>
</tr>
<tr>
<td><strong>Claim Total:</strong></td>
<td></td>
<td></td>
<td>$4,250.05</td>
<td>$2,665.09</td>
<td>$333.84</td>
<td></td>
</tr>
</tbody>
</table>

**Your itemized responsibility to provider:**

<table>
<thead>
<tr>
<th>Deductible (+)</th>
<th>Copay (+)</th>
<th>Coinsurance (+)</th>
<th>Non-Covered (-)</th>
<th>Amount You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>$174.20</td>
<td>$0.00</td>
<td>$80.98</td>
<td>$0.00</td>
<td>$255.16</td>
</tr>
</tbody>
</table>

**This total does not reflect any payments/copays you made at the time of service. Please wait for a provider bill before making a payment.**
<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Type of Service</th>
<th>Notes*</th>
<th>Amount Billed (-)</th>
<th>Plan Discounts (-)</th>
<th>Your Plan Paid (**)</th>
<th>Amount You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/10/2014</td>
<td>OFFICE VISITS</td>
<td>D1</td>
<td>$138.00</td>
<td>$17.14</td>
<td>$100.86</td>
<td>$20.00</td>
</tr>
<tr>
<td>Claim Total:</td>
<td></td>
<td></td>
<td>$138.00</td>
<td>$17.14</td>
<td>$100.86</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

---

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Type of Service</th>
<th>Notes*</th>
<th>Amount Billed (-)</th>
<th>Plan Discounts (-)</th>
<th>Your Plan Paid (**)</th>
<th>Amount You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/10/2014</td>
<td>OFFICE VISITS</td>
<td>05</td>
<td>$138.00</td>
<td>$138.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Claim Total:</td>
<td></td>
<td></td>
<td>$138.00</td>
<td>$138.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Use this EOB statement as a reference or retain as needed.
### Claim Detail for JANE DOE

**Provider:** K ROSENZWEIG  
**Claim Number:** 452050049001  
**Patient Account Number:** 1025056A

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Type of Service</th>
<th>Notes*</th>
<th>Amount Billed</th>
<th>Plan Discounts</th>
<th>Your Plan Paid</th>
<th>Amount Owed</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/09/2014</td>
<td>SPECIAL MEDICAL</td>
<td>D1</td>
<td>$140.00</td>
<td>$102.01</td>
<td>$38.39</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$140.00</td>
<td>$102.01</td>
<td>$38.39</td>
<td></td>
</tr>
</tbody>
</table>

**Claim Total:**

<table>
<thead>
<tr>
<th></th>
<th>Deductible (+)</th>
<th>Copay (+)</th>
<th>Coinsurance (+)</th>
<th>Non-Covered (-)</th>
<th>Amount Owed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td>$7.60</td>
<td>$0.00</td>
<td>$7.60</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td>$7.60</td>
<td>$0.00</td>
<td>$7.60</td>
</tr>
</tbody>
</table>

**Notes:**

**05 -** BENEFITS ARE DENIED FOR THIS SERVICE. THIS SERVICE WAS PREVIOUSLY REVIEWED AND PROCESSED. IF THIS IS A CORRECTED CLAIM, THE PROVIDER MUST SUBMIT AND INDICATE IT IS A CORRECTED CLAIM. IT MUST SHOW THE ORIGINAL SERVICES AND CHARGES AS WELL AS THE CORRECTIONS.

**D1 -** THE DISCOUNT SHOWN IS YOUR SAVINGS. YOUR NETWORK PHYSICIAN OR HEALTH CARE PROVIDER HAS AGREED TO THE PLAN DISCOUNT. THE AMOUNT YOU OWE MAY INCLUDE WHAT YOU NEED TO PAY IF YOU HAVE REACHED A BENEFIT LIMIT ON COVERED HEALTH SERVICES. IF YOU NEED MORE INFORMATION ABOUT YOUR BENEFITS, PLEASE GO TO YOUR MEMBER WEBSITE OR PLAN DOCUMENTS.

**D2 -** THE DISCOUNT SHOWN IS YOUR SAVINGS. YOUR NETWORK FACILITY OR HEALTH CARE PROVIDER HAS AGREED TO THE PLAN DISCOUNT. THE AMOUNT YOU OWE MAY INCLUDE WHAT YOU NEED TO PAY IF YOU HAVE REACHED A BENEFIT LIMIT ON COVERED HEALTH SERVICES. IF YOU NEED MORE INFORMATION ABOUT YOUR BENEFITS, PLEASE GO TO YOUR MEMBER WEBSITE OR PLAN DOCUMENTS.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: United-Healthcare Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573. The request for your review must be made within 180 days of the date you receive this statement. If you request a review of your claim denial, we will complete our review not later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

STD-EOB  
000000548807554

**Use this EOB statement as a reference or retain as needed**
Availibility of Consumer Assistance/Ombudsman Services

There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-4EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-363-2789.

Your state consumer assistance program may also be able to assist you at:
Arkansas Insurance Department, Consumer Services Division
1200 West Third St.
Little Rock, AR 72201
Toll-free telephone: 1-855-332-2227.
Web site: Insurance.consumers@arkansas.gov

If we continue to deny the payment, coverage or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-888-270-5311.

Meet Your Needs Online

At almost anytime day or night, you can review claims, check eligibility, locate a network physician, request an ID card, refill prescriptions if eligible, obtain more information on EOB content and more! For immediate, secure self-service visit www.myuhc.com.

Myuhc Registration

You can register and begin using myuhc in the same session. Navigate to www.myuhc.com to register. The information required for registration is on your insurance ID card (first name, last name, member ID, group number and date of birth).

Maintaining the privacy and security of individuals’ personal information is very important to us at UnitedHealthcare. To protect your privacy, we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier. You may see the unique individual identifier on UnitedHealthcare correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBs), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer care professional at the number shown at the top of this Statement.

Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

Use this EOB statement as a reference or retain as needed
## Account Summary

### Summary of Deductible and Out of Pocket
**Plan Year: 2014**

<table>
<thead>
<tr>
<th>Relation</th>
<th>Annual Amount</th>
<th>(-)Applied to Date</th>
<th>(=&gt;) Remaining Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,000.00</td>
<td>$1,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$4,000.00</td>
<td>$1,033.59</td>
<td>$2,966.44</td>
</tr>
<tr>
<td><strong>OUT OF NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$2,000.00</td>
<td>$0.00</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$10,000.00</td>
<td>$0.00</td>
<td>$10,000.00</td>
</tr>
</tbody>
</table>

### FAMILY

<table>
<thead>
<tr>
<th>Relation</th>
<th>Annual Amount</th>
<th>(-)Applied to Date</th>
<th>(=&gt;) Remaining Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$2,000.00</td>
<td>$1,000.00</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$8,000.00</td>
<td>$2,108.56</td>
<td>$5,891.44</td>
</tr>
<tr>
<td><strong>OUT OF NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$4,000.00</td>
<td>$0.00</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$20,000.00</td>
<td>$0.00</td>
<td>$20,000.00</td>
</tr>
</tbody>
</table>

### Definitions of Key Terms

- **Applied to Date:** The total amount of money applied to your deductible or out of pocket as of this EOB statement.
- **Copay:** A fee you pay each time you see a provider, receive a service, or fill a prescription.
- **Out of Pocket:** The out of pocket maximum is the dollar amount you pay before your plan benefit starts paying at 100% for eligible health care services. Please refer to your plan documents for specific information on what costs apply to the maximum amount.

### VERY IMPORTANT

After Human Resources processes your (EOB) Explanation of Benefits it is passed on to Accounts Payable to pay you.

Accounts Payable will direct deposit your money into your checking/savings account.

If you have **NOT** set up a direct deposit with Accounts Payable, please do so now. The website for the Direct Deposit form is:

http://uca.edu/financialaccounting/files/2013/01/Direct-Deposit-Form-Faculty-Staff-Students1.xlsx
Changes made to account information must be received by the Accounts Payable/Travel Office 10 working days prior to the expected date of reimbursement/payment.

Employee Signature

Date

<table>
<thead>
<tr>
<th>S= Savings</th>
<th>C=Chequing</th>
<th>Account Number</th>
<th>Bank Routing Number</th>
<th>Bank Name</th>
</tr>
</thead>
</table>

A voided check is attached: [ ] Yes [ ] No

Please use the same check account that is currently being used for payroll to ensure the correct bank account number is used.

NOTE: You must provide the bank name, routing number, and account number even if it is the same one that is being used for payroll to ensure the correct bank account number is used.

You must attach a voided check for the account information listed below for new direct deposits or indicate by putting a check mark in the box.

To receive Accounts Payable/Tavel, call process pay card

Please read this section and completely fill out the required information. If you are making a change, you must complete all account information in order of priority.

For accuracy of the bank information I have provided and inaccuracy information will delay the implementation of my direct deposit.

I understand that UCA is not responsible for accuracy of the bank information I have provided and inaccuracy information will delay the implementation of my direct deposit.

I hereby authorize and request UCA to have my reimbursement/fees paid directly deposited to the designated checking or savings account as indicated. I also authorize UCA to initiate any correction (debit) entries to my account in order to correct any errors for which I have been reimbursed. The financial institution named above is also authorized to initiate any correction (credit) entries to my account in order to correct any errors for which I have been reimbursed.

I hereby authorize and request UCA to have my reimbursement/fees paid directly deposited to the designated checking or savings account as indicated. I also authorize UCA to initiate any correction (debit) entries to my account in order to correct any errors for which I have been reimbursed. The financial institution named above is also authorized to initiate any correction (credit) entries to my account in order to correct any errors for which I have been reimbursed.

[ ] Cancel Direct Deposit Participation
[ ] Change in Current Bank and/or Account
[ ] New Enrollment

Department

Work Phone

Home Phone

Employee ID

Student

Retiree

Part-time Staff

Part-time Faculty

Full-time Staff

Full-time Faculty

Please check status:

Fax: 501-450-6319

University of Central Arkansas

Revised 10/1/2012